Maryland
GOVERNOR'S OFFICE OF CRIME PREVENTION, YOUTH, AND VICTIM SERVICES

Maryland Governor's Office of Crime Prevention, Youth, and Victim Services
Sexual Assault Reimbursement Unit (SARU)
100 Community Place, Crownsville, MD 21032

Authorization For Sexual Assault Forensic Medical Examination

This form is to be submitted with an itemized bill, and UB-04 CMS-1450 or OMB-0938-1197 1500 form. Submit mandatory forms for reimbursement to the Sexual Assault Reimbursement Unit (SARU) within 90 days of the exam. Reimbursement claims are subject to the guidelines of the SARU. All fields must be completed. Please provide a remittance address if it is different from the facility address.

Patient Information

Patient Full Name: Popovich (Last) Alicia (First) Marie (Middle)

Patient DOB: 1/11/93 (mm/dd/yy) Patient Medical Record Number: M08533788

Patient Age: 28 Patient Race: C

Patient Gender: ☐ Male ☑ Female ☐ Transgender ☐ Other: _____

Patient Address: 111 East South St. Apt. 302 Fred. MD 21701 (County) (Zip Code)

Date & Time of Sexually-Based or Sexually Related Crime: 7/4/21 (mm/dd/yy) 0200 (Approximate Time)(AM/PM)

Location of Sexually-Based or Sexually Related Crime: Fred., Fred, MD (City/County/State)

Date and Time of Forensic Exam: 7/4/21 (mm/dd/yy) @ 0530 (Approximate Time) (AM/PM)

Blind Report/Anonymous Exam: ☐ YES ☒ NO

Police Department Contacted: Fred. City Police Officer Name: Det. McKinney

470 (Badge #) (District) (Phone)

Police Case Number OR Property Held Number: 21-49724

Other Case Number or Identifier: _____

Healthcare Facility Information

Healthcare Facility: Frederick Health

Healthcare Professional Conducting Examination: Anne Palmer FNP A/P

Facility Phone Number: 240-566-3300 Facility Fax: _____

Billing Email Address: _____

Appointment Type: ☑ Initial Examination ☐ Follow Up Care

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nPEP/HIV Prophylaxis Treatment Reimbursement Claim & Prescription Form

This form is to be submitted with an itemized bill, SARU SAFE Reimbursement Form, and UB-04 CMS-1450 or OMB-0938-1197-1500 form. Submit mandatory form(s) for reimbursement to the Sexual Assault Reimbursement Unit (SARU) within 90 days of the exam. Reimbursement claims are subject to the guidelines of the SARU. All fields must be completed. Please provide a remittance address if it is different from the facility address.

Patient Information

Patient's Full Name: Popovich (Last) Alicia (First) Marie (Middle)

Patient's DOB: 1/11/93 (mm/dd/yy) Patient Medical Record Number: M08537888

Patient Age: 28 Patient Race: C

Patient Gender: ☐ Male ☑ Female ☐ Transgender ☐ Other: _____

Patient's Address: 111 East South St. Apt. 302 (County) 21701 (Zip Code)

Delivery Address: _____
(If applicable) (Address) (City) (State) (Zip Code)

Date & Time of Sexually-Based or Sexually Related Crime: 7/4/21 (mm/dd/yy) ~0200 (Approximate Time)(AM/PM)

Location of Sexually-Based or Sexually Related Crime: Fred, Fred. MD (City/County/State)

Date and Time of Forensic Exam, if applicable: 7/4/21 ~ 0930 (mm/dd/yy) (Approximate Time) (AM/PM)

(A "sexually-based assault" includes any rape, sexual assault, or sexual child abuse as outlined in Maryland Criminal Law Articles 3-303 through 3-308)

Healthcare Facility Information

Healthcare Facility Providing HIV Exposure Assessment & Treatment: Frederick Health

Facility Phone Number: 240-566-3300 Facility Fax: _____

Billing Email Address: _____

Appointment Type: ☑ Initial Examination ☐ Follow Up Care

nPEP/HIV Prophylaxis Reimbursement Form Continued

Patient Name: Alicia Paporich

nPEP/HIV Prophylaxis Treatment Authorization

I hereby authorize Fred. Health Hosp (Hospital/Healthcare Facility) and A. Palmer FNP AP (Qualified Healthcare Professional/Examiner) to conduct an assessment of HIV exposure risk in accordance with current guidelines. Additional medical assessment and treatment may include a sexual assault forensic exam to gather information and evidence as to an alleged sexual assault.

In addition, I hereby authorize the transmittal of the below list of forensic medical services and treatment rendered to me to the Criminal Injuries Compensation Board's Sexual Assault Reimbursement Unit (SARU) for the purpose of providing authority for the SARU to pay the physician, qualified healthcare provider, or hospital for the services rendered to me, including nPEP/HIV prophylaxis. I understand that I do not have to obtain a full Sexual Assault Forensic Exam (SAFE) in order to access the full course of nPEP/HIV prophylaxis treatment. Additionally, I understand that my personal information, including my medical chart, narrative of the assault, and photographs/video will not be disclosed as a requirement for the qualified healthcare provider to obtain reimbursement.

Signed: Alicia Paporich (Print Name) [signature] (Signature)

Relationship to patient: self (self, guardian, authorized surrogate) Date: 7-11-21 (mm/dd/yy)

Authorization For Sexual Assault Forensic Examination Continued

Authorization for Medical Examination, Collection of Evidence, and Release of Information

I hereby authorize Fred. Health Hosp (Hospital) and A. Paul FNP-A/P (Qualified Healthcare Professional/Examiner) to conduct a medical assessment and treatment which may include a sexual assault forensic exam to gather information and evidence as to an alleged sexual assault, including the collection of blood, urine, tissue, or other specimens and clothing and the taking of photographs and/or video.

In addition, I hereby authorize the transmittal of the below list of forensic medical services and treatment rendered to me to the Criminal Injuries Compensation Board's Sexual Assault Reimbursement Unit (SARU) for the purpose of providing the authority for the SARU to pay the physician, qualified healthcare provider, or hospital for the services rendered to me and for the collection of evidence. I understand that my personal information including medical chart, narrative of the assault, and photographs/video cannot be disclosed as a requirement to obtain reimbursement pursuant to Criminal Proceedings §11-1007.

Signed: Alicia Poporich (Print Name) (Signature)

Relationship to patient: self (self, guardian, authorized individual) Date: 7-4-21 (mm/dd/yy)

Physician Certification of Sexual Assault Treatment to Validate Reimbursement

I hereby attest and affirm to the best of my knowledge that Alicia Poporich (Patient's full name) was treated for injuries sustained as a result of alleged rape, sexual assault, or child sexual abuse in accordance with COMAR 10.12.02.5.I certify that any items billed to the SARU for reimbursement are for the treatment of injuries sustained as a result of alleged rape, sexual assault, or child sexual abuse.

Signed: Daniel Delauter (Treating Physician) (Print) (Signature) RN (License #) FNP-A/P

Date: 07/04/21 (mm/dd/yy)

nPEP/HIV Prophylaxis Reimbursement Form Continued

Patient Name: Alicia Bosnich

Sexual Assault Forensic Exam Information

Did the patient receive nPEP treatment without having a SAFE exam? ☐ Yes ☒ No
If patient received a SAFE, Date of SAFE: 7/04/2021 (mm/dd/yy)
Hospital where the patient received SAFE: Frederick Health Hospital

Required Data

Was the patient assessed for exposure to HIV? ☒ Yes ☐ No
Did the patient qualify to receive nPEP? ☒ Yes ☐ No
Did the patient choose to receive nPEP? ☒ Yes ☐ No
Was a follow-up care referral made? ☒ Yes ☐ No
If yes, where: Frederick Health
Which payment option will be utilized for billing?
- ☒ Sexual Assault Reimbursement Unit
- ☐ Pharmaceutical patient assistance program
- ☐ Public/Private Health Insurance

If public/private health insurance is utilized, which insurance company? N/A

Laboratory Services

☒ Pregnancy Test (Qualitative): ☒ Serum ☐ Urine
☐ Positive ☒ Negative
☒ HIV rapid antigen/antibody: ☐ Positive ☒ Negative
☒ CBC
☒ CMP
☒ Hepatitis B (HBV) serology ☐ Hep b surface antigen ☐ Hep b surface antibody ☒ Hep b core antibody
☒ Hepatitis C (HCV) antibody
☒ Syphilis serology
☒ Gonorrhea
☐ Chlamydia
☒ Other Trichomonas, BV, Candidia

Authorization For Sexual Assault Forensic Examination Continued

Patient Name: Alicia Poporich

Medical Services

☑ Medical Screening Examination ☑ Forensic Exam ☐ Radiology ☐ Surgical Consult
☐ Other (please explain):_____

Signature: [signature] FNE AMP
Forensic Nurse Examiner (License #)

Laboratory Services

Blood Panels: ☑ CBC ☑ CMP
Pregnancy Test: ☐ Serum ☐ Urine (HCG Qualitative only)

Sexually Transmitted Infections:
☑ Genital culture ☐ Urine NAAT ☑ Wet Prep
☑ Gonorrhea: ☑ *Oral* ☐ *Rectal* ☑ *Vaginal*
☑ Chlamydia: ☑ *Oral* ☐ *Rectal* ☑ *Vaginal*
☑ Trichomoniasis ☑ RPR, VDRL, Syphilis ☐ Herpes Culture ☑ Hepatitis Panel ☑ HIV
antigen/antibody
☐ Rectal Culture

Drug Facilitated Sexual Assault (DFSA):
Was DFSA suspected? ☐ Yes ☑ No
If yes, please select all laboratory services rendered:
☐ Toxicology Panel (see attached invoice):
☐ Urine ☐ Blood
☐ Other/Explain:_____

Prescribed Medications

Emergency Contraception:	☑ Yes	☐ No	
Pain Medication:	☐ Tylenol (Acetaminophen)	☐ Motrin (Ibuprofen)	☐ Lidocaine
	☐ Ketorolac		
Antibiotics:	☑ Rocephin (Ceftriaxone)	☑ Flagyl (Metronidazole)	☐ Doxycycline
	☑ Zithromax (Azithromycin)	☐ Suprax (Cefixime)	☐ Cipro (Ciprofloxin)
	☐ Erythromycin	☐ Levaquin (Levofloxacin)	
Vaccines:	☐ Tetanus	☐ Hepatitis	
	☐ Human Papillomavirus (HPV)	☐ Hepatitis B Immune Globulin (HBIG)	
Prophylaxis:	☑ nPEP therapy*		

If patient receives nPEP therapy, complete the nPEP/HIV Prophylaxis Treatment and Reimbursement Claim Form

Anti-nausea: ☑ Zofran (Ondansetron)
☐ Other/Explain:_____

nPEP/HIV Prophylaxis Reimbursement Form Continued

Patient Name: Alicia Popovich Date: 7/4/21

Patient DOB: 1/11/93 Patient Phone #: 301-514-0218

Patient Weight: 75 Kg lbs Allergies: NKDA

nPEP Medication Regimen

Number of days/doses of nPEP medication provided at facility: ☐ 1 ☐ 3 ☐ 5 ☐ 7 ☑ ~~28~~

☐ Other: _____

If less than a full 28-day regimen was supplied, where was the patient referred to obtain the balance of treatment?

☐ Retail Pharmacy ☐ Health Department ☐ Hospital Pharmacy ☐ HIV/Immunology Clinic

☐ Other _____

CDC Recommended Regimens (2016):

The National Clinician Consultation Center offers free non-occupational post-exposure prophylaxis consultation Mon-Fri 9 am to 8 pm EST and weekend and holidays 11 am to 8 pm. Call 888-448-4911 for more information.

☑ **Otherwise healthy adults and adolescents ≥ 13-years old:** A 3-drug regimen of Truvada + Isentress OR Tivicay

☐ **Adults and adolescents ≥ 13-years old with renal dysfunction (creatinine clearance <59 mL/min):** A 3-drug regimen of Combivir + Isentress OR Tivicay (dosages adjusted to degree of renal function)

☐ **Children age 2-12 years old:** A 3-drug regimen of tenofovir DF, emtricitabine, and raltegravir, with dosages adjusted to age and weight

☐ **Children age 4 weeks – 2 years old:** A 3-drug regimen of zidovudine, lamivudine, and raltegravir or lopinavir/ritonavir with dosages adjusted to age and weight

Please check orders to be used:

☑ **Truvada** (emtricitabine 200 mg and tenofvir DF 300 mg) – 1 tablet daily

☑ **Isentress** (raltegravir 400 mg) – 1 tablet twice a day

☐ **Tivicay** (dolutegravir 50 mg) – 1 tablet daily (Avoid during first trimester or for women of child-bearing age)

☐ **Combivir** (zidovudine 300 mg and lamivudine 150 mg) – 1 tablet twice a day

☐ Stribild (EVG/COBI/FTC/TAF)

☐ Ondansetron (Zofran)

☐ Other: _____

Was a follow-up care referral made? ☑ Yes ☐ No

If yes, provide referral location: Frederick Health

Provider Name: Daniel Delawter NPI: _____

Provider Signature: [signature] RN FNP Phone #: 240-566-3300

Medical Services

☐ Physician/Qualified Healthcare Provider

☐ Other medical:

_____

Authorization For Sexual Assault Forensic Examination Continued

Patient Name: Alicia Poporich

Required Data

Was the patient assessed for exposure to HIV? ☑ Yes ☐ No

Did the patient qualify to receive nPEP? ☑ Yes ☐ No

Did the patient choose to receive nPEP? ☑ Yes* ☐ No

Complete and submit the separate nPEP/HIV Prophylaxis Treatment Reimbursement Claim & Prescription Form

Did the patient elect to receive nPEP treatment without a SAFE exam? ☐ Yes ☑ No

Was a follow-up care referral made? ☑ Yes ☐ No

If yes, where: Frederick Health Hospital

Number of days/doses of nPEP treatment provided at facility: ☐ 1 ☐ 3 ☐ 5 ☐ 7 ☑ 28 Other: _____

(A "sexually-based assault" includes any rape, sexual assault, or sexual child abuse as outlined in Maryland Criminal Law Articles 3-303 through 3-308)

AUTHORIZATION FOR SEXUAL ASSAULT FORENSIC MEDICAL EXAMINATION and FOR DISCLOSURE OF MEDICAL INFORMATION

STEP 1

Hospital Name: Fred. Health Hosp Brought by: Friend

Police Case #: 21-49734 OR Property Held #: —

OR Other Case #: —

Name of Victim: Alicia Popovich

DOB: 1/11/93 Age: 28 Sex: F Race: C

Address: 111 East South St. Apt 302 Zip: 21701 Phone: 240-215-7301

Date/Time of Incident	If Police Notified:	Admitted to ER:	Examination:
Date: 7/4/21	Date: 7/4/21	Date: 7/4/21	Date: 7/4/21
Time: 0200	Time: 0547	Time: 0532	Time: 0930

Requesting Officer, if notified (Name, District, Telephone):

Authorization for medical examination, collection of evidence, and release of information: I Hereby authorize Fred Health Hosp (Hospital) and A. Bowe FNE NP (Physician/Examiner) to conduct a physical examination of my person, including a gynecological examination, to gather information and evidence as to an alleged sexual assault, including the collection of blood, urine, tissue or other specimens and clothing and the taking of photographs and/or video. In addition, I hereby authorize the transmittal of a copy of all medical reports created pursuant to the examination, including any laboratory reports, to the Department of Health and Mental Hygiene's Sexual Assault Reimbursement Unit (SARU) for the purpose of providing the authority for SARU to pay the hospital and/or physician/examiner for services rendered to me and for the collection of evidence. Furthermore, I hereby authorize the transmittal of a copy of all medical reports, other information created, and evidence collected pursuant to the examination to the Police Department of the jurisdiction where the alleged crime took place, when and if I elect to report the alleged sexual assault to the police, and to the Office of the State's Attorney of the jurisdiction, when and if I elect to cooperate with a prosecution of the alleged sexual assault. The authorization for release of my medical records is valid for one year from the date of signing.

Signed: Alicia [signature] Date: 7-4-21
(Responsible Party) (Print) (Signature)

Witness: [signature] FNE NP Date: 7/4/21

PLEASE USE BALL POINT PEN FOR COMPLETION

Popovich, Alicia Marie
Account # A089774276
Medical Rec # M0853708
Service/Admit Date
Birthdate 01/11/1993
F 28

A089774276

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MEDICAL FORENSIC REPORT: POST-STRANGULATION EXAMINATION

Confidential Document: Restricted Release

Step #1: General Information

Patient's Name: Alicia Popovich D.O.B. 1/11/93

Case# 21-49724 Police Agency FCPD Det./Officer Det. McElmore

Date & Time of Medical Forensic Exam: 7/4/21 0800 Date & Time of Strangulation: 7/4/21 0200

Safe number for contact (240) 215 - 7301 Scheduled follow up date: _____

Text messages permitted? (Yes) No

Focused PMH

Respiratory: (Asthma, Smoker, etc.) NA

Neurological: (stroke, seizures, other) NA

Skin: NA

Medications: NA

Affect/Demeanor: (circle appropriate responses) sad (crying) tearful labile flat anxious withdrawn angry scared non-verbal confused interactive (calm)

Other: _____

Have you been strangled/choked before? (No)
Yes: If so, how many times? _____
When? _____

Step 2: Medical Release

MEDICAL RELEASE

To All Health Care Providers: Having been advised of my right to refuse, I hereby consent to the release of my medical/dental records, radiographs, collection of evidence such as, photography, swabs, blood and urine specimens related to this incident to law enforcement, and the States' attorney's Office.

Patient Signature: [signature] Relationship to patient: pt. Date & Time: 7/4/21 0900

Witness (Print): A. Palmer FNE A/I Signature: [signature] Date/Time: 7/4/21 0900

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Step #3: Description of Strangulation Event:

Hx provided by: (parent, guardian, other) patient

History of event:

"I was walking home from down town around 0200" "I was grabbed from behind with one hand & around body by his other hand & arm" "dragged me down alley" "I tried to get away" "Pushed me down to my knees on concrete" "(past train tracks)" "He told me to lift dress up I screamed" "He got on top of me" "He punched me & slammed & slapped me in face multiple times" "He put his "Dick" in my Vagina & mouth repeatedly back & forth" "He said he would kill me" "He threw my shoes off & smashed my phone" "When he was done he pulled me up & said I can't believe I did this look e your face" "I just needed you" "I told him I had to go home to let out dog" "He let me go" ☐ See attached.

Symptoms and/or Internal Injury:

Patient Responses: (Check appropriate boxes)

Breathing Changes	Voice Changes	Swallowing Changes	Behavioral Changes	OTHER
☐Difficulty Breathing ☐Hyperventilation ☐Unable to breathe ☐Other:	☐Raspy voice ☑Hoarse voice ☑Coughing ☐Unable to speak	☐Trouble swallowing ☐Painful to swallow ☑Neck Pain ☐Nausea /Vomiting ☐Drooling	☐Agitation ☐Amnesia ☐PTSD ☐Hallucinations ☐Combativeness	☐Dizzy ☑Headaches ☐LOC ☐Urination ☐Defecation

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Method and/or Manner:

How and where was the patient strangled? (One Hand (R or L)) Two hands
Forearm (R or L) Knee/Foot (R or L)

Ligature (Describe): ~

How long? ~ Seconds ~ Minutes ~5 min Smothered? If yes, with what? ~

From 1 to 10, how hard was the suspect's grip? (Low): 1, 2, 3, 4, 5, (6), 7, 8, 9, 10 (high)

From 1 to 10, how painful was it? (Low): 1, 2, 3, 4, 5, 6, 7, 8, (9), 10 (high)

Multiple attempts: 2 Multiple Methods? hands

Is the suspect RIGHT or LEFT handed? (Circle one) unknown

Did the suspect say anything while strangling the patient, before and/or after?
"Don't scream I'll kill you, and the shut up shut up"

Was patient shaken simultaneously while being strangled? Yes (No)
Straddled? (Yes) No
Held against wall? Yes (No)
If yes to any of the above questions, explain: ~

Was the patient's head pounded against wall, floor or ground? (Yes) No
If yes, explain:
on Concrete

Did the patient's feet lift off of the floor? Yes (No)

What did the patient think was going to happen?
"I thought I was gonna die"

How or why did the suspect stop strangling patient?
"Because I stopped screaming"

What was the suspect's demeanor?
"crazy"

Describe what the suspect's face looked like during strangulation?
"I couldn't see well it, it was dark" "mad angry"

Where did prior incidents of strangulation occur? Prior domestic violence? Prior threats? Explain.
NA

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Step #4: Medical Assessment:

Medical Assessment: (Check appropriate boxes)

Face	Eyes & Eyelids	Nose	Ear	Mouth
☑ Red or flushed ☐ Petechiae ☐ Scratch marks ☐ Other_____	☐ Petechiae to R and/or L eyeball ☐ Petechiae to R and/or L eyelid ☐ Scleral hemorrhages ☑ Vascular congestion/ Dilation ☐ Other_____	☐ Bloody nose ☐ Broken nose ☐ Petechiae ☐ Other_____	☑ Petechiae (external and/or ear canal) ☐ Bleeding from ear canal ☑ Other swelling bruising	☑ Contusion/Bruising ☐ Swollen tongue ☑ Swollen lips ☑ Cuts/abrasions ☐ Laceration ☐ Petechiae ☐ Other_____
Under Chin	**Chest**	**Shoulders**	**Neck**	**Head**
☐ Redness ☐ Scratch marks ☐ Contusion/ Bruise(s) ☐ Abrasions ☐ Other_____	☑ Redness ☑ Scratch marks ☐ Contusion/Bruise(s) ☐ Abrasions ☐ Other_____	☑ Redness ☐ Scratch marks ☑ Contusion/ Bruise(s) ☑ Abrasions ☐ Other_____	☑ Redness ☑ Scratch marks ☑ Finger nail impressions ☑ Contusion/ Bruise(s) ☐ Swelling ☐ Ligature mark ☐ Other_____	☐ Petechiae (on scalp) ☐ Hair pulled ☐ Swelling ☐ Skull fracture ☐ Concussion ☐ Other_____

Step #5: Photos/Body Map

Photo documentation completed? (Yes) No If "no", explain: —

Number of photos: 95 Video? Yes (No) Other method of documentation? _____

Photographer: A. Palmer FNE A|P Assisted by: —

☑ Photo Log Completed

☐ See Other Documentation: —

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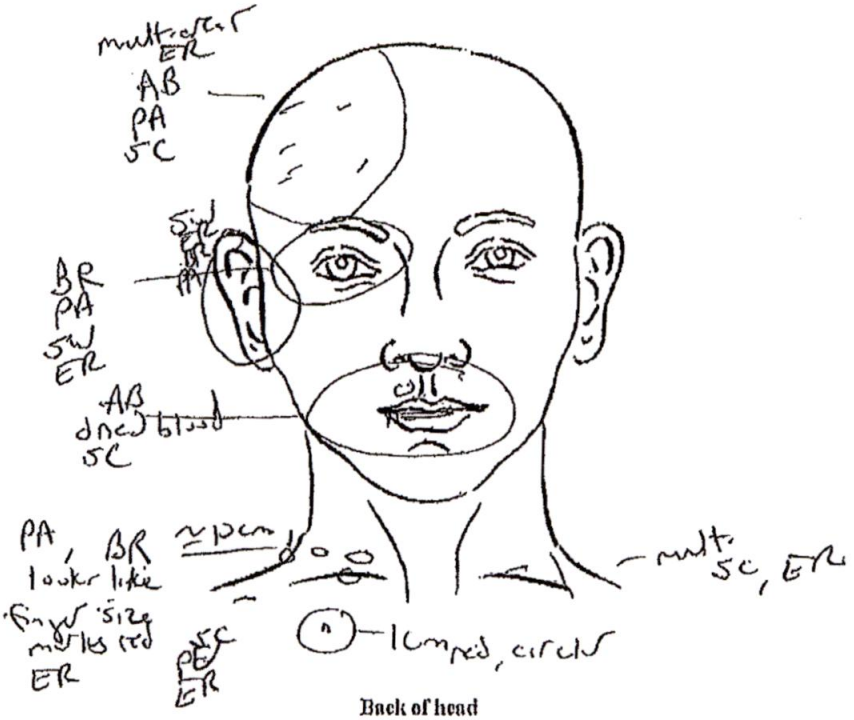
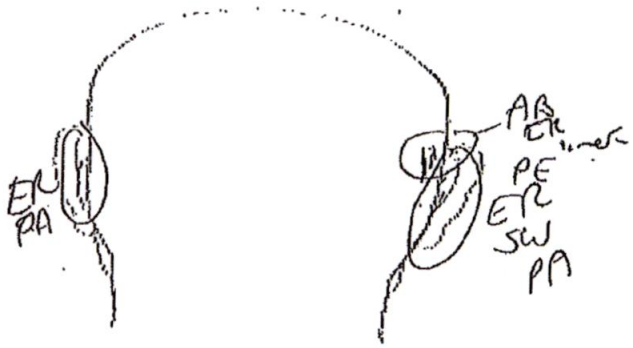
Front of Face



Back of head



Map Legend

AB Abrasion	HP Hand Print	SC Scratches
BR Bruise/contusion	LA Laceration	SE Subcutaneous Emphysema
BU Burn	LI Ligature Mark	SH Subconjunctival Hemorrhage
CU Cut/incision	PA Pain	SW Swelling
ER Erythema	PE Petechiae	FE Forensic Evidence

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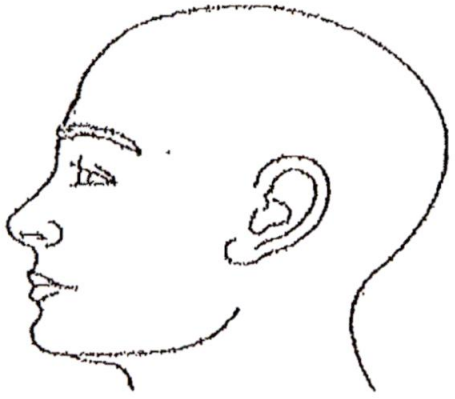
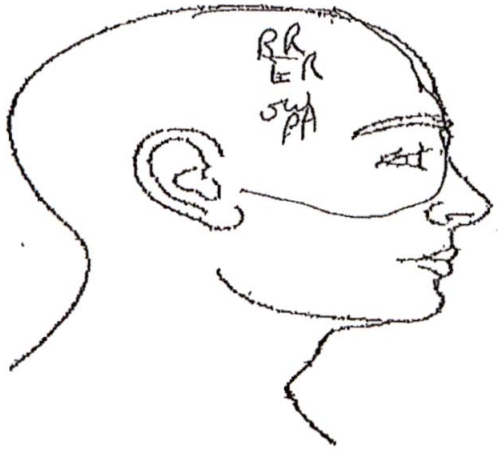
Left Side of Head



Right Side of Head



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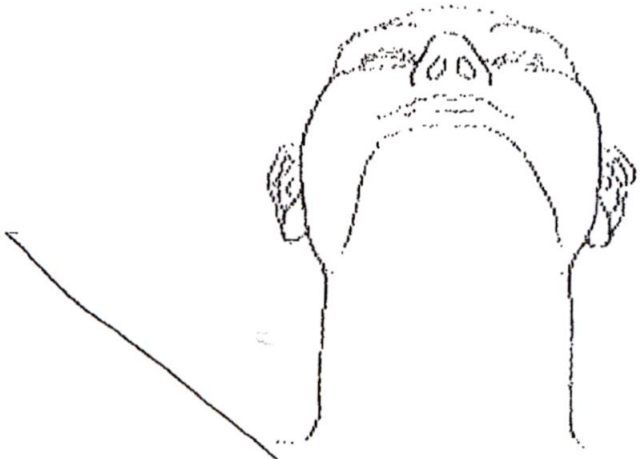
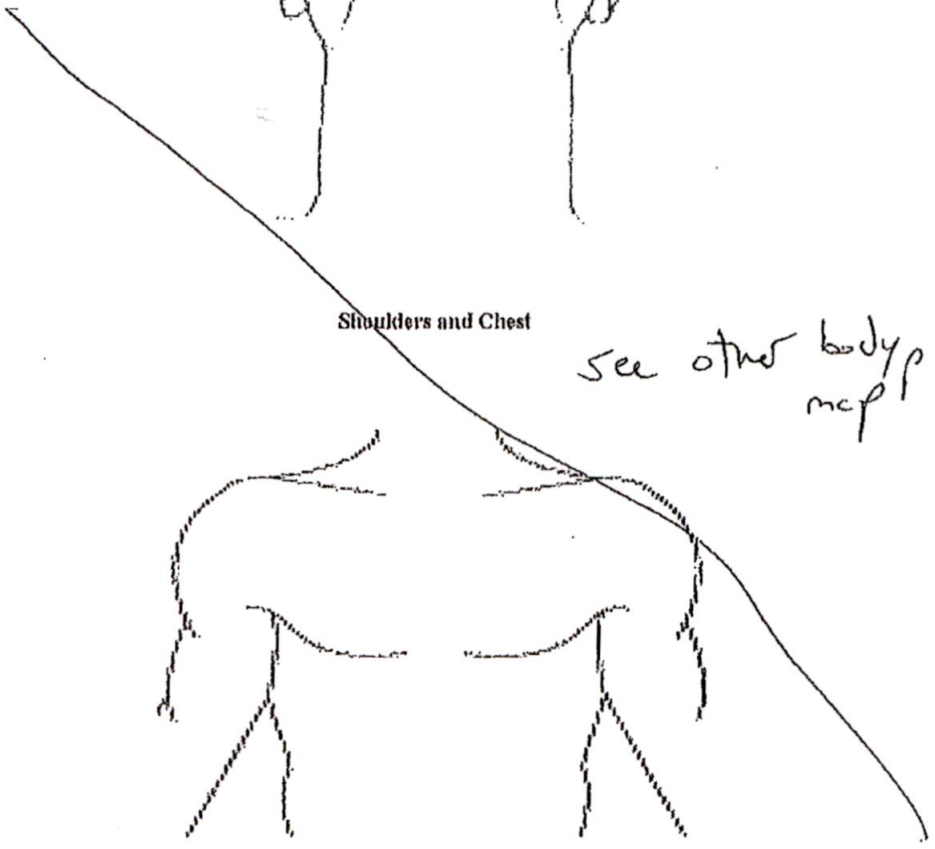
Under Chin and Neck



Shoulders and Chest

see other body map



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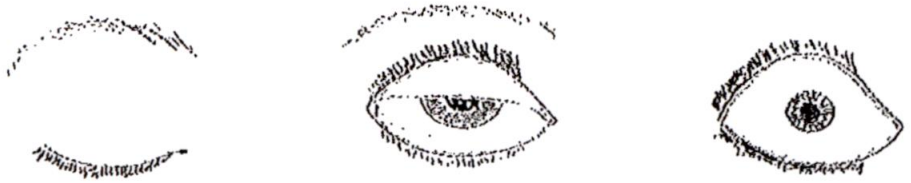
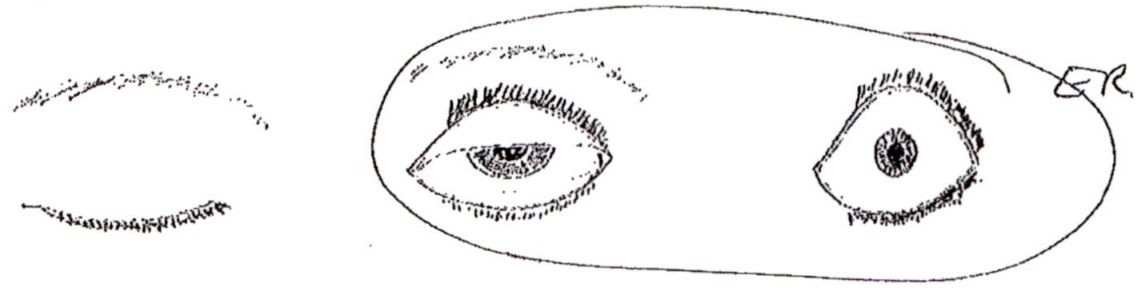
Outer Eyelid/Upper & Lower Conjunctiva/Sclera & Mouth-Palate/Tongue/Frenulum/Lips & Teeth

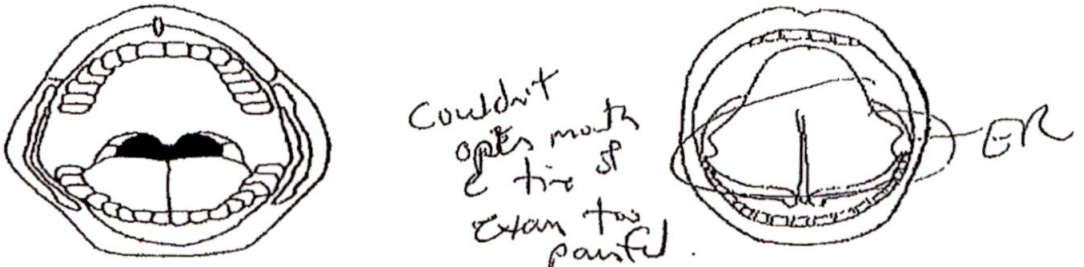
Right

Due to swelling & pain unable to open eye of OD



Left





Check all that apply:

- ☐ Forensic evidence collection completed. (See appropriate evidence collection and COC forms for complete list).
- ☑ Lethality Assessment completed.
- ☐ Laryngoscopic examination completed. NA

Vascular Studies Completed: ☐ MRI/MRA ☐ Ultrasound ☒ ~~CT~~

Examiner Name: A. Palmer FNP Signature: [signature] Date: 7/4/21 Time: 1400

Frederick Memorial Hospital gratefully acknowledges the work of Sally Sturgeon, DNP and Dr. Bill Smock for their assistance in the development of this form.

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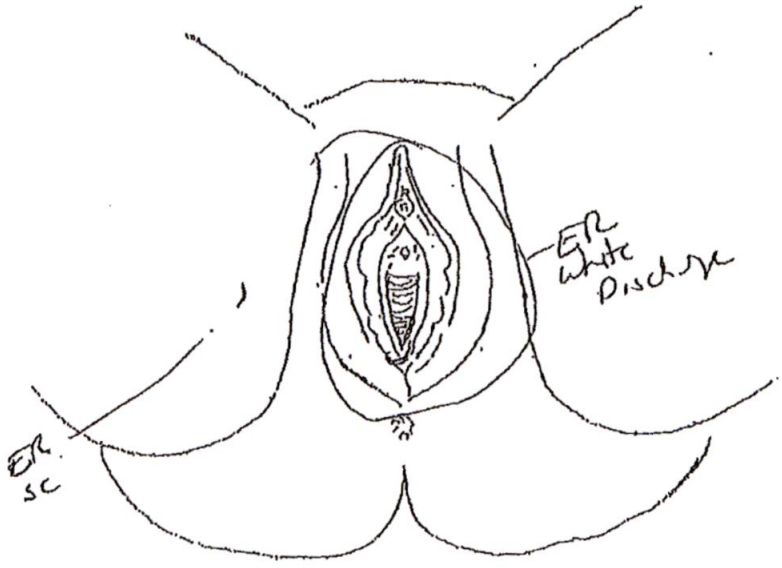
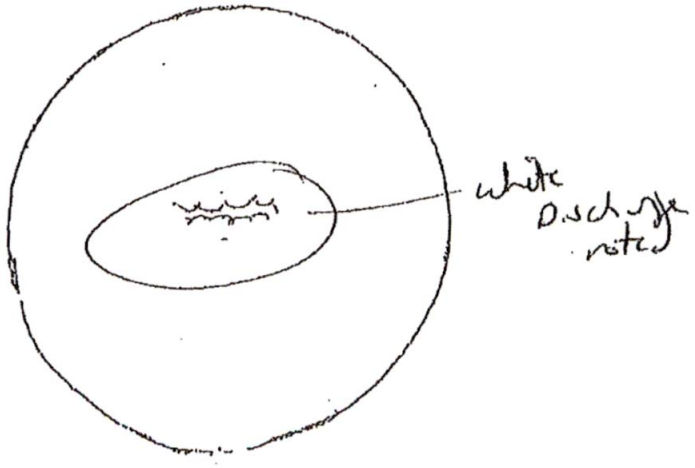
Frederick, MD 21701
240-566-3300

FORENSIC NURSE EXAMINER PROGRAM - ADULT ANATOMICAL FIGURES





TANNER LEVEL ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☑ 5

EXAMINER'S NAME: A- Palmer FNE A/P

Popovich, Alicia Marie
Account # A089774276
Medical Rec # M0853788
Service/Admit Date
Birthdate 01/11/1993
F 28

A089774276

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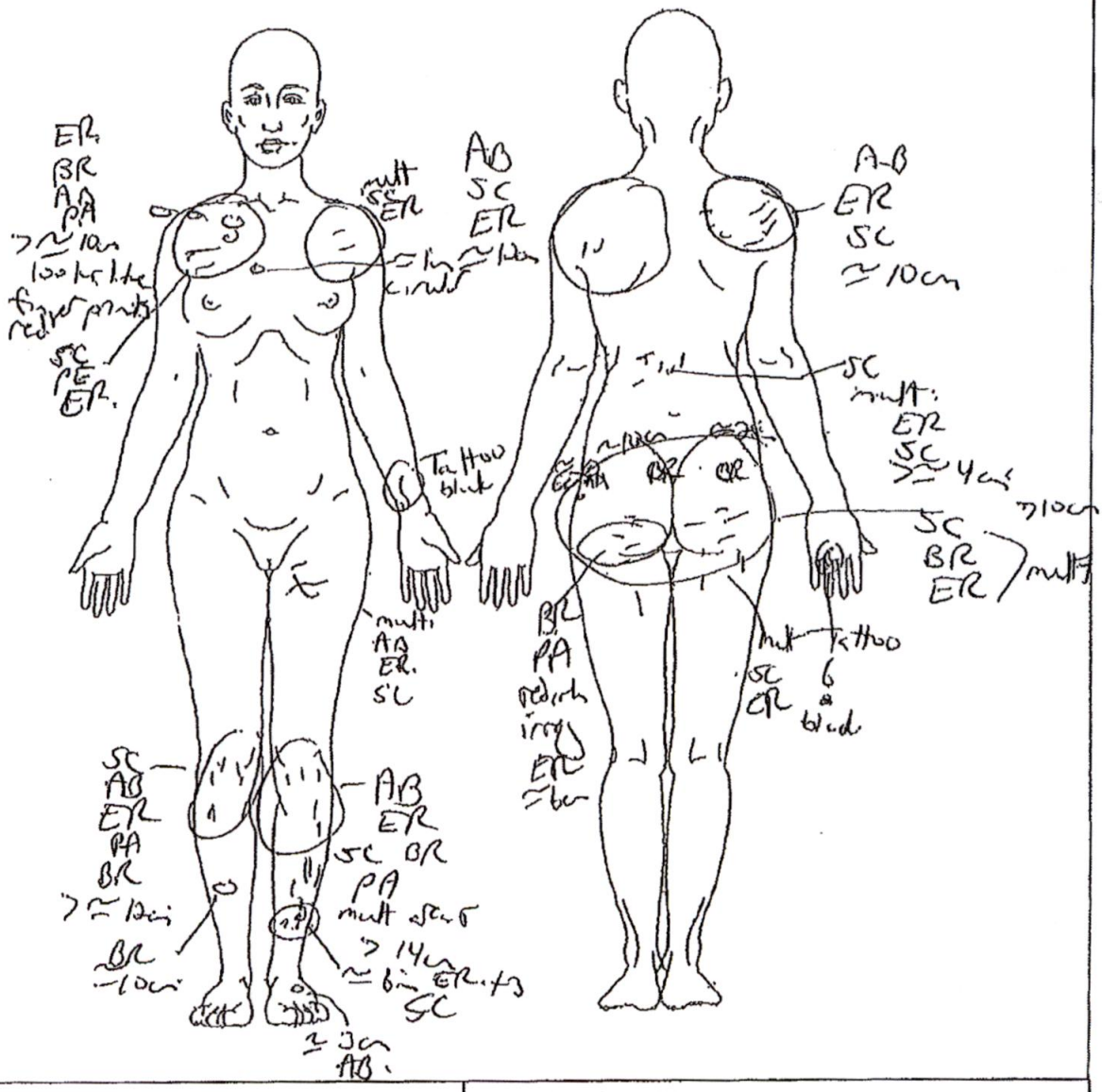
FORENSIC NURSE EXAMINER PROGRAM - ADULT ANATOMICAL FIGURES



TANNER LEVEL ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☒ 5

EXAMINER'S NAME: A. Palmer FNE A/P

Popovich, Alicia Marie
Account # A089774276
Medical Rec # M0853788
Service/Admit Date
Birthdate 01/11/1993
F 28

A089774276 A089774276

FREDERICK MEMORIAL HOSPITAL
400 West 7th Street
Frederick, MD 21701
240-566-3300

MEDICAL FORENSIC REPORT: DOMESTIC VIOLENCE EXAMINATION

A. GENERAL INFORMATION

1. Patient's Last Name: Popovich | First Name: Alicia | M.I.: M | Case Number: 21-49724

2. Street Address (optional): 111 East Southst. Apt. 302 | City: Frd. | County: Frd. | State: MD | Zip Code: 21701 | Telephone (optional) (Home) (Work) (Safe): 240-215-7307

3. Age: 28 | DOB: 1/11/93 | Gender: (F) M MTF FTM | Ethnicity (check all that apply): ☐ White ☐ Black / African American ☐ Hispanic / Latino ☐ Asian ☐ American Indian / Alaskan Native ☐ Native Hawaiian / Other Pacific Islander ☐ Other

4. Name of Facility Where Forensic Exam Performed: Frederick Memorial Hospital | Address of Facility: 400 W. 7th Street, Frederick MD 21701

5. Patient Arrival Date	Time	Patient Discharge Date	Time	6. Exam Started Date	Time	Exam Completed Date	Time
7/4/21	0532	7/4/21	c 1317	7/4/21	1000	7/4/21	c 1310

7. Interpreter Used ☒ No ☐ Yes | Language Used:
Name of Interpreter: | Telephone:
Affiliation of Interpreter: ☐ Facility Interpreting Services ☐ Contracted Agency, specify: ☐ Family ☐ Friend ☐ Other, specify:

B. MANDATORY SUSPICIOUS INJURY REPORT

1. Name of Person Making Mandated Telephone Report to Law Enforcement Agency | Date | Time

2. Name of Person Taking Telephone Report | Name of Law Enforcement Agency | ☐ Written Report Submitted

☐

Law Enforcement Officer | Name of Law Enforcement Agency | ID Number

☐

Law Enforcement Officer | Name of Law Enforcement Agency | ID Number

Telephone | Date | Time | Case Number

E. PATIENT INFORMATION

1. I have been informed that victims of crime are eligible to submit crime victim compensation claims to the Maryland Victim Compensation Fund for out-of-pocket medical expenses, psychological counseling, loss of wages, and job retraining and rehabilitation. A (initial)
2. I have been informed about domestic violence advocacy services or a social services professional who can provide me with counseling and support. A (initial)

F. PATIENT CONSENT

1. I understand that a forensic medical examination for evidence of domestic violence can, with my consent, be conducted by a health care professional to discover and preserve evidence of the assault. If conducted, the report of the examination and any evidence obtained will be released to law enforcement authorities. I understand that the examination may include the collection of reference specimens at the time of the examination or at a later date. I understand that I may withdraw consent at any time for any portion of the examination. A (initial)
2. I understand that collection of evidence may include audio/visual recordings and photographing injuries and that these photographs may include the genital area. A (initial)
3. I hereby consent to a forensic medical examination for evidence of domestic violence. A (initial)
4. I understand that data without patient identity from this report may be collected for health and forensic purposes, and provided to health authorities and other qualified persons with a valid educational or scientific interest. A (initial)

☒ Patient ☐ Parent ☐ Guardian ☐ Surrogate

Patient Name: Alicia Popovich | Signature: [signature] | Date: 7-4-21

Forensic Nurse Examiner: [illegible] | Signature: [signature] | Date: 7/4/21

Name Printed First M/P

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G. CURRENT ASSAULT HISTORY

1. Examination audio and/or videotaped ☑No ☐Yes ☐Audio ☐Video

2. Name of person providing history: | Relationship to Patient: pt.

3. Date(s) of Assault: 7/4/21 | Time/Time Frame of Assault: 0200

Patient Identification: Date: 7/4/21

4. Describe Physical Surroundings of Assault: outdoors, on concrete, down alley

5. Patient Description of Assault: see other documentation

6. Assailant(s)

	Assailant's Name	DOB	Age	Gender	Ethnicity
#1	unknown				

Relationship to Patient: (check all that apply)
☐Spouse ☐Cohabitant/Domestic Partner ☐Dating Relationship ☐Child Together
☐Former Spouse ☐Former Cohabitant/Domestic Partner ☐Former Dating Relationship ☐Other
Current Whereabouts: ☑Unknown ☐In Custody ☐Known Location

	Assailant's Name	DOB	Age	Gender	Ethnicity
#2					

Relationship to Patient: (check all that apply)
☐Spouse ☐Cohabitant/Domestic Partner ☐Dating Relationship ☐Child Together
☐Former Spouse ☐Former Cohabitant/Domestic Partner ☐Former Dating Relationship ☐Other
Current Whereabouts: ☐Unknown ☐In Custody ☐Known Location:

7. Methods employed by assailant(s) and circumstances

	No	Yes	If yes:
Weapons	☑	☐	☐Firearm ☐Knife ☐Blunt Object ☐Other:
Threatened?	☑	☐	Describe:
Displayed?	☑	☐	Describe:
Used?	☑	☐	Describe:
Injuries?	☐	☐	Describe:

Physical blows ☑by hands ☐by feet ☐by head ☐Other, describe:
☑Grabbing ☐Hitting ☐Pinching ☑Slapping ☑Punching ☐Other, describe: used hands multiple

Hair pulling? ☑No ☐Yes ☐If yes, describe:
Physical restraints ☑No ☐Yes ☐If yes, describe:

Strangulation

One Hand	Two Hands	Forearm
Frontal Assault	Frontal Assault	Frontal Assault
✓ Rear Assault	Rear Assault	Rear Assault

☐Ligature, describe: N/A

grabbed from behind

Bites ☐No ☐Yes, describe:
Burns ☐Thermal ☐Chemical ☐Other
Threat(s) of harm ☐No ☑Yes If yes, target of threat: ☑Patient ☐Children ☐Pet(s) ☐Property ☐Other, describe: "To kill me"
Describe what was said or done:

Sexual acts with assailant as part of this assault? ☐No ☐Unsure ☑Yes If yes: ☑Forced ☐Coerced
Involuntary use of alcohol/drugs ☑No ☐Yes If yes: ☐Forced ☐Coerced ☐Suspected
If yes: ☐Alcohol ☐Drugs Describe:

☐ ☐ ☐

9. Post assault hygiene
☐Bath / shower / wash ☐Clothing change ☐Other, describe: gave clothes + police

H. CURRENT SYMPTOMS REPORTED BY PATIENT
(check all that apply)

Symptoms	From This Event	From Past Event(s)
Neurological		
Headache	✓	
Dizziness		
Memory/Concentration Problems	✓	
Lightheaded		
Visual Changes		
Hearing Changes		
Loss of Consciousness		
Numbness		
Weakness		
Other:		
Psychological		
Acute Anxiety		
Depression		
Suicide Ideation		
Homicide Ideation		
Other:		
Cardiorespiratory		
Voice Change	✓	
Coughing	✓	
Shortness of Breath		
Chest Pain		
Palpitations		
Other:		
Gastrointestinal		
Sore Throat	✓	
Difficulty Swallowing		
Nausea		
Vomiting		
Diarrhea		
Abdominal Pain		
Hematemesis		
Rectal Bleeding		
Rectal Pain		
Penis/Testicular Pain		
Other:		
Urogenital		
Pelvic Pain	✓	
Dysuria		
Vaginal Bleeding		
Vaginal Discharge		
Loss of bladder control		
Other:		
Musculoskeletal		
Extremity Pain		
Neck Pain		
Back Pain		
Deformity		
Other:		
Other:		
Other:		

Note

Patient Identification: Date: 7/4/21

I. PATIENT HISTORY

1. Disability ☑No ☐Yes
   If yes: ☐Cognitive ☐Physical ☐Blind ☐Deaf/HOH ☐Mental

2. History of prior physical assault(s) with this assailant?
   ☑No ☐Yes If yes, past injuries to patient? ☐No ☐Yes, describe:

3. Prior history of forced or coerced sexual relations with this assailant? ☐No ☐Yes, describe:
   Approximate Date(s):

4. Has patient sought medical care for prior assault(s) by this assailant? ☐No ☐Yes
   If yes, name of facility:
   If yes, under what name(s)?
   If yes, approximate date(s):

5. Obstetrical History Pregnant? ☐No ☐Yes ☐Unknown
   If yes, any possible problems related to current assault(s)?
   ☐No ☐Yes, describe:
   Any possible problems in past pregnancies related to past assault(s) by this assailant?
   ☐No ☐Yes, describe:

6. Name(s) of Children/Dependent Adults Living in Household

Name(s) of Children/Dependent Adults Living in Household	Present During Assault(s) No	Yes	UNK	Gender	DOB or Age
				M F	
				M F	
				M F	
				M F	
				M F	

7. Voluntary Use of Alcohol/Drugs ☐No ☑Yes
   Any voluntary alcohol use within 12 hrs prior to assault? ☐No ☑Yes
   Any voluntary drug use within 96 hrs prior to assault? ☑No ☐Yes
   Any voluntary drug ☐or alcohol ☐ use between time of assault and forensic exam? ☑No ☐Yes
   List drug(s) used:

8. Are there other ways the patient's life has been impacted by behaviors of this assailant?
   see other documentation

J. GENERAL PHYSICAL EXAMINATION

1. Blood Pressure	Pulse	Respiration	Temp
130/85	78	18	98°

2. Describe general physical appearance:
in hospital gown, multi-bruised @ right eye swollen shut

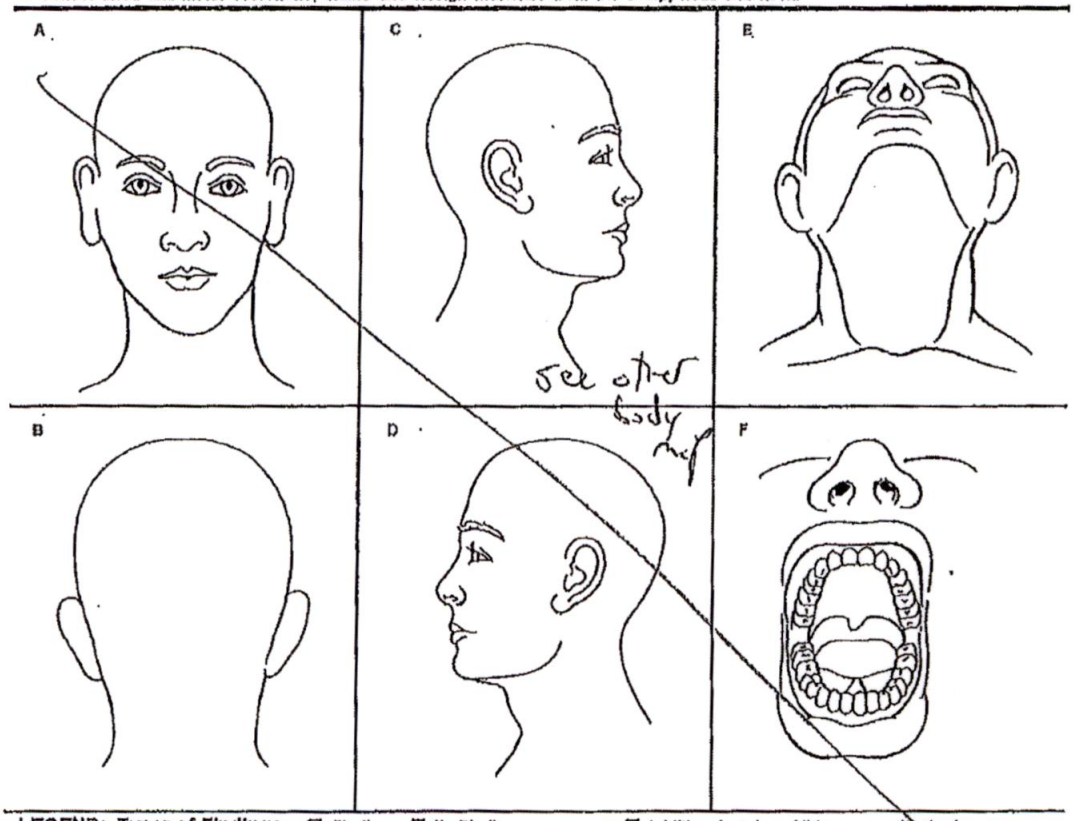
3. Describe general demeanor:
cooperative eye contact

Patient Identification: Date: 7/4/01

4. Describe condition of clothing upon arrival. Collect outer and under clothing if applicable. ☐ Not Applicable
in hospital gown, clothes collected by police

5. Examine the face, head, ears, hair, scalp, neck, and mouth for injury. Document findings using photographs, diagrams, legend, and consecutive numbering system.

6. Collect dried and moist secretions, stains and foreign materials from the scalp, head and neck.



LEGEND: Types of Findings ☐ Findings ☐ No Findings ☐ Additional copies of this page attached

AB Abrasion	DS Dry Secretion	IN Induration	OI Other injury (describe)	TA Tooth Avulsed
BI Bite	EC Ecchymosis	IW Incised Wound	PE Petechiae	TD Tooth Decay
BU Burn	ER Erythema (redness)	LA Laceration	PS Potential Saliva	TF Tooth Fractured
BR Bruise/contus.	FB Foreign Body	MS Moist Secretion	SI Suction Injuries	TM Tooth Missing
CS Control Swab	F/H Fiber/Hair	OF Other Foreign Materials (describe)	SW Swelling	V/S Vegetation/Soil
DE Debris	FT Frenulum Torn		TE Tenderness	
DF Deformity				

Locator #	Type	Description	Locator #	Type	Description

J. GENERAL PHYSICAL EXAMINATION(continued)

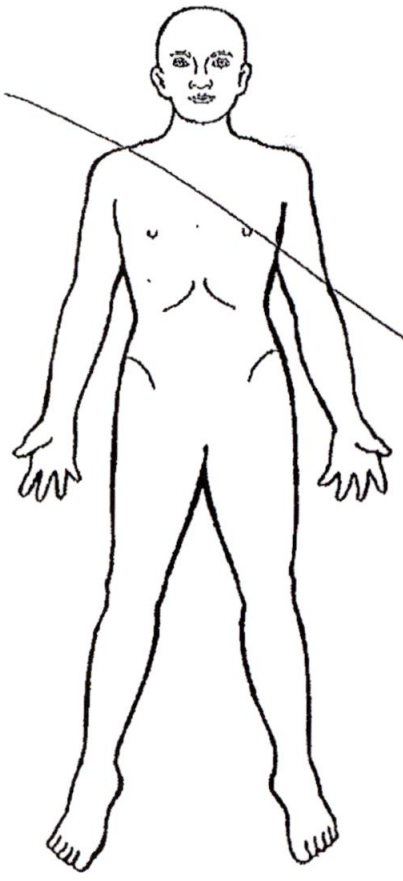
7. Conduct a physical examination of body and extremities. Record findings using photographs, diagrams, legend, and a consecutive numbering system.

8. Collect dried and moist secretions, stains and foreign materials from body ☒ Findings ☐ No Findings

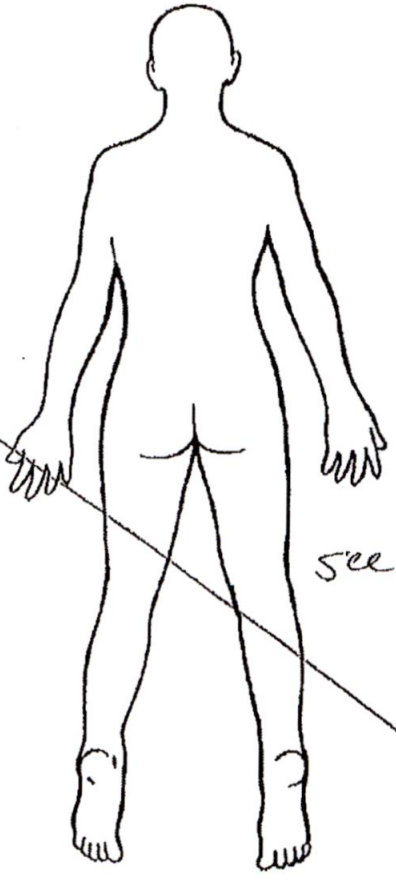
9. Collect fingernail scrapings/swabbing according to local policy ☒ Done ☐ Not Applicable

Patient Identification: Date: 7/4/21

G



H



see other body map

LEGEND: Types of Findings ☐ Findings ☐ No Findings ☐ Additional copies of this page attached

AB Abrasion	DS Dry Secretion	IW Incised Wound	PE Petechiae
BI Bite	EC Ecchymosis	LA Laceration	PS Potential Saliva
BR Bruise/contusion			
BU Burn	ER Erythema (redness)	MS Moist Secretion	SI Suction Injuries
CS Control Swab	FB Foreign Body	OF Other Foreign Materials (describe)	SW Swelling
DE Debris	F/H Fiber/Hair	OI Other Injury (describe)	TE Tenderness
DF Deformity	IN Induration		VS Vegetation/Soil

Locator #	Type	Description	Locator #	Type	Description

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J. GENERAL PHYSICAL EXAMINATION (continued)

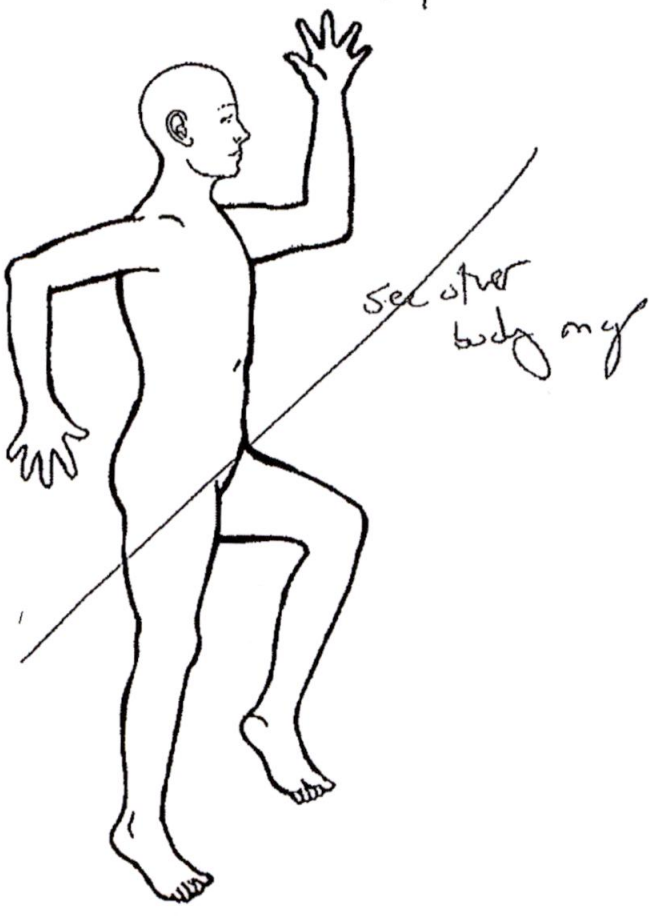
10. Use diagrams I and J to record findings to lateral or medial aspect of trunk or extremities. Record findings.

11. If genital injuries sustained, use pages 6 and 7 from Forensic Medical Report: Acute Adult/Adolescent Sexual Assault Examination form to document findings.
Are pages 6 & 7 attached? ☑ Yes ☐ No ☐ Not applicable

Patient Identification: Date: 7/4/01

I

J



LEGEND: Types of Findings ☑ Findings ☐ No Findings ☐ Additional copies of this page attached

AB Abrasion	DS Dry Secretion	IW Incised Wound	PE Petechiae
BI Bite	EC Ecchymosis	LA Laceration	PS Potential Saliva
BR Bruise/contusion	ER Erythema (redness)	MS Moist Secretion	SI Suction Injuries
BU Burn	FB Foreign Body	OF Other Foreign Materials (describe)	SW Swelling
DE Debris	F/H Fiber/Hair	OI Other Injury (describe)	TE Tenderness
DF Deformity	IN Induration		VS Vegetation/Soil

Locator #	Type	Description	Locator #	Type	Description
1	AB, SC, PA, BR	mult areas			

A089774276

Popovich, Alicia Marie
Account # A089774276
Medical Rec # M0853780
Service/Admit Date
Birthdate 01/11/1993
F 28

A089774276

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K. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing Collected ☐ No ☐ Yes	Clothing Placed in Evidence Kit	Clothing Placed in Paper Bag
Bra ☐		
Dress/skirt ☐		
Jacket/sweater ☐		
Nylons ☐	with police	
Pants/shorts ☐		
Shirt/top ☐		
Shoes (1 or 2) ☐		
Socks (1 or 2) ☐		
Underwear ☐		
Undershirt ☐		
Other ☐		

2. Foreign Materials Collected

	N/A	No	Yes	Collected by:
Swabs/suspected DNA	☐	☐	☑	[illegible]
secretions	☑	☐	☐	
Fiber/loose hairs	☑	☐	☐	
Soil/debris/vegetation	☑	☐	☐	
Swabs/suspected subst.	☑	☐	☐	
Foreign body	☑	☐	☐	
Fingernail scrapings	☐	☐	☑	[illegible]
Control swabs	☐	☐	☑	[illegible]

Other, describe:

3. Laboratory Results Additional Page ☐ Yes ☐ No
Pregnancy ☐ Positive ☑ Negative
Additional Labs: ☐ No ☐ Yes, specify:

4. X-Ray/Imaging Results Additional Page ☐ Yes ☑ No
☐ No ☑ Yes, specify: CT

5. Toxicology Samples

N/A	No	Yes	Time	Collected by:
☑	☐	☐		
☑	☐	☐		

6. Reference Samples ☐ Blood ☑ Saliva ☐ Buccal ☐ N/A
Collected by: [illegible]

7. Photo Documentation
☐ No ☑ Yes Digital ☐ Video ☐ Other
Photography by: A. Palmer FNE # images 55
Recommend follow-up photographs to be taken in 1-2 days.
☐ No ☐ Yes ☑ Not applicable

8. Voice recording for strangulation injuries
☑ No ☐ Yes If yes: ☐ Audio ☐ A/V
If yes, obtained by: ☐ Examiner ☐ Law Enforcement

I. SUMMARY OF KEY FINDINGS
multiple documented injurys see body map, see other documentation.

Patient Identification: Date: 7/4/21

M. PERTINENT ISSUES AFFECTING EXAMNATION
Swollen R eye, unable to open unable to open mouth d/t pain

N. PERSONNEL INVOLVED
Name (print clearly)
History taken by: A. Palmer FNE A/P
Physical exam performed by: A. Palmer FNE A/P
Specimens labeled and sealed by: A. Palmer FNE A/P
Assisted by: ☑ N/A
Additional narrative by: ☑ N/A
Signature of Examiner [illegible] FNE Date 7/4/21

O. EVIDENCE	DISTRIBUTION OF Released To
Clothing (items not placed in evidence kit)	
Evidence Kit	
Medical/Forensic Record	See COC
Toxicology samples	
Recording(s) ☐ Audio ☐ A/V	

P. DISPOSITION AND FOLLOW UP
☑ Discharged ☐ Admit ☐ Follow Up Exam Scheduled
☐ Cross Reporting to: ☐ CPS ☐ APS ☐ N/A
☐ Referral to domestic violence advocacy services
☑ Safety plan discussed with patient
☐

Printed Name Anne Palmer
Signature [illegible] FNE A/P
Agency FHH

Popovich,Alicia Marie
A089774276 M0863786
28 F
Alicia 01/11/1993

FREDERICK MEMORIAL HOSPITAL
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Frederick, MD 21701
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MEDICAL FORENSIC REPORT: SEXUAL ASSAULT EXAM - ADULT

A. GENERAL INFORMATION (print or type)

1. Name of patient: Alicia Popovich — Case Number: 21-4924

2. Address: 111 East South St Apt. 302 — City: Frd. — County: Frd. — State: MD — Telephone (W) (H): 240-215-7001

3. Age	DOB	Gender	Ethnicity	Date/time of arrival	Date/time of discharge
28	1/11/93	M (F)	C	7/4/21 @ 0532	7/4/21 @ 1317

B. REPORTING AND AUTHORIZATION

Jurisdiction (☐ city ☐ county ☐ other):

1. Telephone report made to law enforcement agency

Name of Officer	Agency	ID Number	Telephone	Reported by: Name	Date	Time
Det. McKinney	FCPD					

2. Responding Officer | Agency | ID Number | Telephone

3. I request a forensic medical examination for suspected sexual assault at public expense.

Law enforcement officer | ID number | Agency

Date/time: | Telephone | Date | Time | Case Number

C. PATIENT INFORMATION

- I have been informed that victims of crime are eligible to submit crime victim compensation claims to the State Victims of Crime (VOC) Compensation Fund for out-of-pocket medical expenses, psychological counseling, loss of wages, and job retraining and rehabilitation. _____ (Initial)

D. HPI:

See documentation on the

☐ See attached.

Popovich,Alicia Marie
A089774276 M0853788
28 F
Alicia 01/11/1993

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E. PATIENT MEDICAL HISTORY

1. Name of person providing history: pt. | Relationship to patient: pt.

2. Pertinent medical history:
- Last menstrual period 6/5/21
- Any recent (100 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of current physical findings? ☑ No ☐ Yes
  If yes, describe:
- Any other pertinent medical condition(s) that may affect the interpretation of current physical findings? ☑ No ☐ Yes
  If yes, describe:
- Any pre-existing physical injuries? ☑ No ☐ Yes
  If yes, describe:

3. Pertinent pre- and post-assault related history:

	No	Yes	Unsure
• Other intercourse within past 5 days?	☑	☐	
If yes, anal (within past 5 days)? When ____	☑	☐	
vaginal (within past 5 days)? When ____	☑	☐	
oral (within past 24 hours)? When ____	☑	☐	
If yes, did ejaculation occur?	☐	☐	☐
If yes, where? ____			
If yes, was a condom used?	☑	☐	☐
• Any voluntary alcohol use within 12 hours prior to assault?	☐	☑	
• Any voluntary drug use within 96 hours prior assault?	☑	☐	
• Any voluntary drug or alcohol use between the time of the assault and the forensic exam?	☑	☐	

*If yes, collection of toxicology samples is recommended according to local policy. ☐ Blood ☐ Urine N/A

4. Post-assault hygiene/activity: ☐ Not applicable if over 120 hours

	No	Yes
Urinated	☐	☑
Defecated	☑	☐
Genital or body wipes	☑	☐
If yes, describe: ____		
Douched	☑	☐
If yes, with what ____		
Removed/inserted tampon ☐ diaphragm ☐	☑	☐
Oral gargle/rinse	☐	☑
Bath/shower/wash	☑	☐
Brushed teeth	☐	☑
Ate or drank	☐	☑
Changed clothing	☐	☑
If yes, describe: gave to police		

5. Assault-related history:

	No	Yes
Loss of memory? If yes, describe: ☐	☑	
Lapse of consciousness? If yes, describe:	☑	☐
*If yes, collection of toxicology samples is recommended according to local policy. ☐ Blood ☐ Urine	N/A	
Vomited? If yes, describe:	☑	☐
Non-genital injury, pain and/or bleeding? If yes, describe: see other documentation	☐	☑
Anal-genital injury, pain, and/or bleeding? If yes, describe: pain	☐	☑

F. ASSAULT HISTORY

1. Date of assault(s): 7/4/21 | # of assault(s): 1

2. Pertinent physical surroundings of assault(s): out doors on concrete

3. Alleged assailant(s) name(s)	Age	Gender	Ethnicity	Relationship to patient: Known	Unknown
#1. unknown		(M) F	Black		✓
#2.		M F			
#3.		M F			
#4.		M F			

4. Methods employed by assailant(s):

	No	Yes	If yes, describe:
Weapons	☐	☐	
Threatened?	☐	☐	
Injuries inflicted?	☐	☐	
Type(s) of weapons?			
Physical blows	☐	☑	hands punching
Grabbing/holding/pinching	☐	☑	grabbing & holding down
Physical restraints	☑	☐	
Choking/strangulation	☐	☑	see other documentation
Burns (thermal and/or chemical)	☑	☐	
Threat(s) of harm	☐	☑	"To Kill me"
Target(s) of threat(s)	☑	☐	
Other methods	☑	☐	

Involuntary ingestion of alcohol/drugs ☑ No ☐ Yes ☐ Unsure
If yes, ☐ Alcohol ☐ Drugs
If yes, ☐ Forced ☑ Coerced ☐ Suspected
If yes, toxicology samples collected: ☐ Blood ☐ Urine ☑ None

6. Injuries inflicted upon the assailant(s) during assault? ☑ No ☐ Yes
If yes, describe injuries, possible locations on the body, and how they were inflicted.
unknown

Popovich,Alicia Marie
A089774276 M0853788
F
26 01/11/1993
Alicia

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240-566-3300

	No	Yes	Attempted	Unsure	Describe:
1. Penetration of vagina by:					"multiple placed "pick" in my mouth & Vagina"
Penis	☐	☑	☐	☐	
Finger	☑	☐	☐	☐	
Object	☑	☐	☐	☐	
If yes, describe the object:					
2. Penetration of anus by:					Describe:
Penis	☑	☐	☐	☐	
Finger	☑	☐	☐	☐	
Object	☑	☐	☐	☐	
If yes, describe the object:					
3. Oral copulation of genitals:					Describe:
Of patient by assailant	☐	☐	☐	☐	"Pick"
Of assailant by patient	☐	☑	☐	☐	"Keep placing penis in my mouth & Vagina"
4. Oral copulation of anus:					Describe:
Of patient by assailant	☑	☐	☐	☐	
Of assailant by patient	☑	☐	☐	☐	
5. Non-genital act(s):	No	Yes	Attempted	Unsure	Describe:
Licking	☑	☐	☐	☐	
Kissing	☑	☐	☐	☐	
Suction injury	☑	☐	☐	☐	
Biting	☑	☐	☐	☐	
6. Other act(s):	No	Yes	Attempted	Unsure	Describe:
	☑	☐	☐	☐	
7. Did ejaculation occur?	No	Yes		Unsure	Describe: "I don't remember"
	☐	☐		☑	
If yes, note location(s):					
☐ Mouth					
☐ Vagina					
☐ Anus/Rectum					
☐ Body surface					
☐ On clothing					
☐ On bedding					
☐ Other					
8. Contraceptive or lubricant products:	No	Yes		Unsure	Describe type/brand, if known:
Foam used?	☑	☐		☐	
Jelly used?	☑	☐		☐	
Lubricant used?	☑	☐		☐	
Condom used?	☑	☐		☐	

Popovich,Alicia Marie
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Alicia

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400 West 7th Street
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240-566-3300

H. GENERAL PHYSICAL EXAMINATION

Record all findings using diagrams, legend, and a consecutive numbering system.

1. Blood Pressure	Pulse	Resp	Temp	2. Date/Time examination started
130/80	72	18	98	7/4/21 @ 0900

3. Describe general physical appearance: multiply bruised noted

4. Describe general demeanor: upset, tears at time eye contact

Patient Identification

5. Describe condition of clothing upon arrival: hospital gown... clothes collected... by police

6. Collect outer and underclothing if indicated. ☐ Not Indicated
7. Conduct a physical examination: ☒ Findings ☐ No Findings
8. Collect dried and moist secretions, stains, and foreign materials from the body. Scan the entire body with an ALS.
☐ Findings ☒ No Findings
9. Collect fingernail swabbings according to local policy.

Diagram A

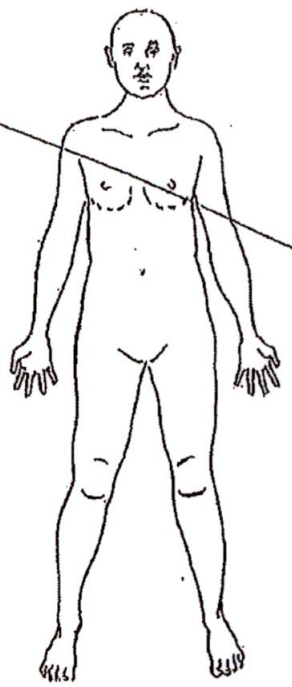
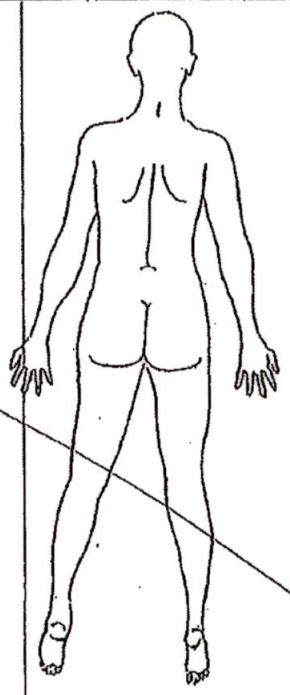


Diagram B



See other body map

LEGEND: Types of Findings

AB Abrasio	DF Deformity	FB Foreign Body	MS Moist Secretion	PE Petechiae	TB Toluidine Blue®
BI Bite	DS Dry Secretion	IN Induration	OF Other Foreign Materials (describe)	PS Potential Saliva	
BU Burn	EC Ecchymosis	IW Incised Wound		SHX Sample Per History	TH Tenderness
BR Bruise/Cont.	ER Erythema (redness)	LA Laceration	OI Other Injury (describe)	SI Suction Injury	V/S Vegetation/Sebaceous oil
CS Control	F/H Fiber/Hair			SW Swelling	ALS Alternate Light Source
DE Swab Debris					

Locator#	Type	Description	Locator#	Type	Description

RECORD ALL CLOTHING AND SPECIMENS COLLECTED ON PAGE 5

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400 West 7th Street
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Popovich,Alicia Marie
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Alicia

I. HEAD, NECK, AND ORAL EXAMINATION

Record all findings using diagrams, legend, and a consecutive numbering system.

1. Examine the face, head, hair, scalp, and neck for injury and foreign materials. ☑ Findings ☐ No Findings
2. Collect dried and moist secretions, stains, and foreign materials from the face, head, hair, scalp, and neck.
   ☑ Findings ☐ No Findings
3. Examine the oral cavity for injury and foreign materials (if indicated by assault history). Collect foreign materials.
   Exam done: ☐ Not applicable ☑ Yes ☐ Findings ☐ No Findings
4. Collect 2 swabs from the oral cavity up to 12 hours post assault

Diagram C

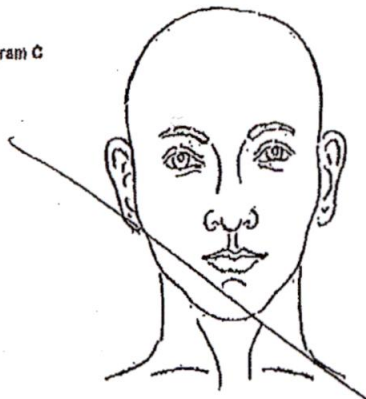
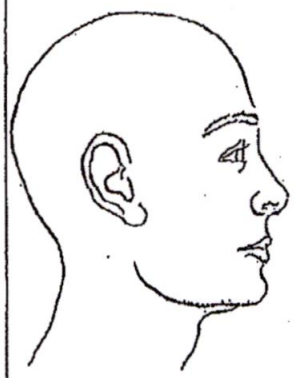


Diagram D



see chart for body map

Diagram E

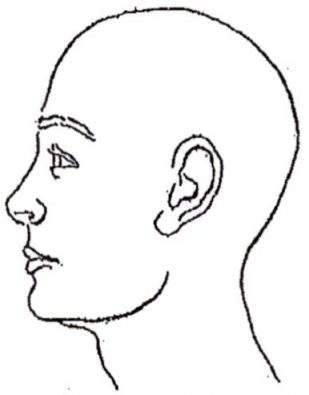
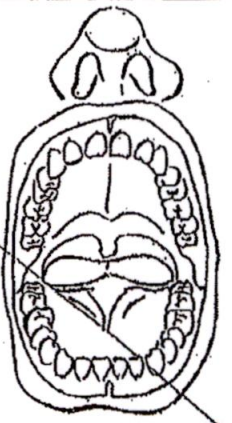


Diagram F



LEGEND: Types of Findings

AB	Abrasio	DF	Deformity	FB	Foreign Body	MS	Moist Secretion	PE	Petechiae	TE	Tolufdine
BI	Bite	DS	Dry Secretion	IN	Induration	OF	Other Foreign	PS	Potential Saliva		BlueⒸ
BU	Burn	EC	Ecchymosis	IW	Incised Wound		Materials (describe)	SH	X Sample Per History	TE	Tenderness
BR	Bruise/Contu.	ER	Erythema (redness)	LA	Laceration	OI	Other Injury	S	Suction Injury	V/S	Vegetation/S
CS	Control	FH	Fibers/Hair				(describe)	SW	Swelling	ALS	oil
DE	Swab Debris										Alternate Light Source

Location#	Type	Description	Location#	Type	Description

RECORD ALL SPECIMENS COLLECTED ON PAGE 8

Popovich,Alicia Marie
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J. GENITAL EXAMINATION - FEMALES

Record all findings using diagrams, legend, and a consecutive numbering system.

1. Examine the inner thighs, external genitalia, and perineal area.
2. Exam method: ☑ Direct visualization ☐ Other magnification

Exam positions/methods:	Separation	Traction	Knee Chest
Supine	☑	☐	☐
Prone	☐	☑	☐

☐ Saline/Water ☐ Moistened swab ☑ Toluidine Blue Dye
☐ Colposcopy ☐ Other

3. Genital Tanner Stage 1☐ 2☐ 3☐ 4☐ 5☑
4. Examine the genital structures. Check the ABN box(es) if there are abuse/assault related findings and describe.

	WNL	ABN	Describe:
Inner thighs	☐	☑	abrasion
Inguinal adenopathy	☐	☐	
Labia majora	☐	☑	Erythema
Labia minora	☐	☑	"
Clitoral hood	☐	☑	"
Perineum	☐	☑	"
Periurethral tissue/urethral meatus	☑	☐	
Perihymenal tissue (vestibule)	☐	☑	Erythema
Hymen ☑ Supine ☐ Prone	☐	☐	
Record morphology:			
☑ Annular			
☐ Crescentic			
☐ Imperforate			
☐ Septate			
Fossa navicularis	☐	☑	Erythema
Posterior fourchette	☐	☑	" redness
Vagina (pubertal adolescents)	☐	☐	
Cervix (pubertal adolescents)	☐	☐	discharge

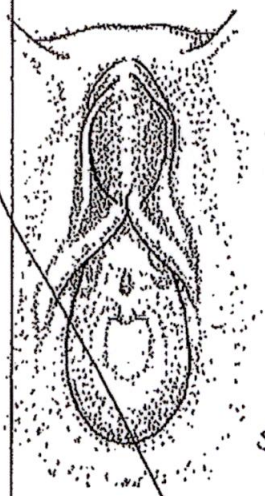
Discharge ☐ No ☑ Yes
If yes, describe:
No Findings ☐

5. Collect dried and moist secretions, stains, and foreign materials. Soak the area with a ALS. ☐ Findings ☐ No Findings
6. Collect swabs.
   ☐ Prepubertal female
   ☑ Collect at least 2 vulvar and 2 vestibular swabs.
   ☐ Pubertal female
   ☐ Collect 3 swabs from the vaginal pool.
   ☐ Collect 2 cervical swabs (if over 48 hours post assault).
7. Collect pubic hair combing or brushing. ☐ Not applicable

Patient Identification

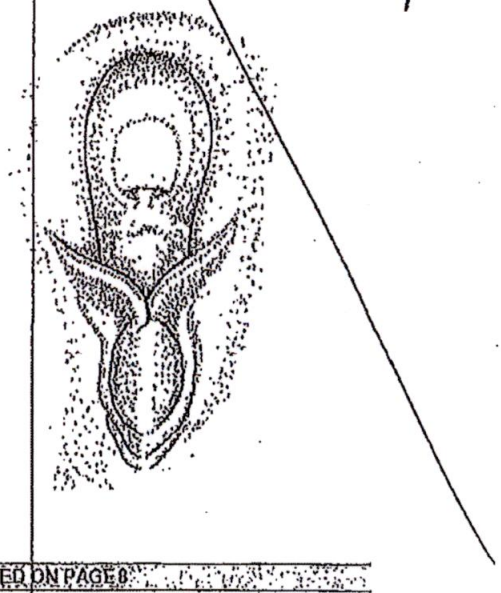
Diagram the position that best illustrates your findings.

Diagram G Genitalia - Supine



see other body map

Diagram H Genitalia - Knee-Chest



LEGEND: Types of Findings

AB	Abrasion	DF	Deformity	LA	Laceration	BH	Subconjunctival Hemorrhage
AL	Avulsion/Loss	DI	Discharge	MS	Moist Secretion	SHX	Sample Pat History
		DS	Dry Secretion	OF	Object Foreign Materials (describe)	SI	Suction Injury
		EC	Ecchymosis			SW	Swelling
		ER	Erythema (redness)	OI	Other Injury (describe)	TD	Toluidine Blue
BI	Bite	FB	Foreign Body	OSC	Other Skin Condition	TE	Tenderness
BU	Burn	FH	Fibrosis	OT	Other	VB	Vegetation/Wart
CS	Contact Grab	GT	Granulation Tissue	PW	Perianal Wart	VL	Vesicular Lesion
CV	Congenital Variation	HC	Hymenal Cleft	PE	Petechiae	ALG	Alt. Lt. Source
		IN	Induration	POW	Positive Genital Wart	BR	Bruise/Contusion
DE	Debris	IW	Incised Wound	PS	Potential Saliva		

Locator #	Type	Description

RECORD ALL CLOTHING AND SPECIMENS COLLECTED ON PAGE 8

Popovich,Alicia Marie
A089774276 M0863788
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28 01/11/1993
Alicia

FREDERICK MEMORIAL HOSPITAL
400 West 7th Street
Frederick, MD 21701
240-566-3300

K. GENITAL EXAMINATION -- MALES ☑ N/A

Record all findings using diagrams, legend, and a consecutive numbering system.

1. Examine the inner thighs, external genitalia, and perineal area. Check the box(es) if there are assault related findings:
   - ☐ No Findings
   - ☐ Inner thighs
   - ☐ Perineum
   - ☐ Foreskin
   - ☐ Glans penis
   - ☐ Penile shaft
   - ☐ Urethral meatus
   - ☐ Scrotum
   - ☐ Testes
2. Circumcised: ☐ No ☐ Yes
3. Collect dried and moist secretions, stains, and foreign materials. Scan the area with an ALS. ☐ Findings ☐ No Findings
4. Collect pubic hair combing or brushing.
5. Collect pubic hair reference samples according to local policy.
6. Collect 2 penile swabs, if indicated by assault history. ☐ N/A
7. Collect 2 scrotal swabs, if indicated by assault history. ☐ N/A
8. Examine the buttocks, anus, and rectum (if indicated by history)

   Exam done: ☐ Yes ☐ Not applicable

   Check the box(es) if there are assault related findings:
   - ☐ No Findings
   - ☐ Buttocks
   - ☐ Perianal skin
   - ☐ Anal verge/folds/rugae
   - ☐ Rectum
9. Collect dried and moist secretions, stains, and foreign materials. ☐ Findings ☐ No Findings
10. Collect 2 anal and/or rectal swabs.
11. Conduct an anoscopic exam if rectal injury is suspected or if there is any sign of rectal bleeding. ☐ Not applicable

    Rectal bleeding: ☐ No ☐ Yes

    If yes, describe: _____
12. Exam position used:
    ☐ Supine ☐ Other Describe:

LEGEND: Types of Findings

AB Abrasion	EC Ecchymosis (bruise)	MS Moist Secretion	SI Suction Injury		
BI Bite	ER Erythema (redness)	OF Other Foreign Materials (describe)	SW Swelling		
BR Bruise/Cont.					
BU Burn	FH Fiber/Hair		TB Toluidine Blue®		
CS Control Swab	FB Foreign Body	OI Other Injury (describe)	TE Tenderness		
DE Debris	IN Induration	PE Petechiae	VS Vegetation/Soil		
DF Deformity	IW Incised Wound	PS Potential Saliva	ALS Alt. Light Source		
DS Dry Secretion	LA Laceration	SHX Sample Per History			

Locator #	Type	Description

Patient Identification

Diagram K

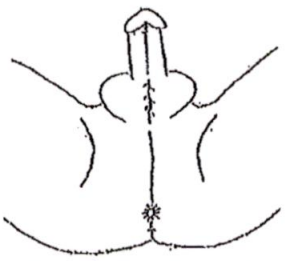


Diagram L

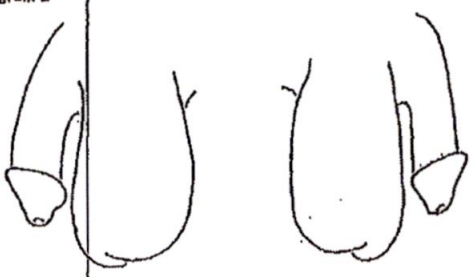
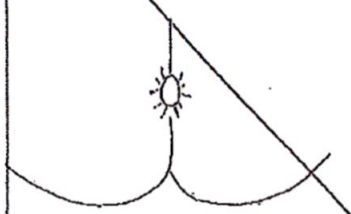


Diagram M

Diagram N



RECORD ALL SPECIMENS COLLECTED ON PAGE 8

Popovich,Alicia Marie
A089774276 M0863708
F
28 01/11/1993
Alicia

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400 West 7th Street
Frederick, MD 21701
240-566-3300

Patient Identification

M. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing placed in evidence kit	Other clothing placed in bags

2. Foreign materials collected

	No	Yes	Collected by:
Swabs/suspected blood	☐	☐	
Dried secretions	☐	☐	
Fiber/loose hairs	☐	☐	
Vegetation	☐	☐	
Soil/debris	☐	☐	
Swabs/suspected semen	☐	☐	
Swabs/suspected saliva	☐	☐	
Swabs/+ALS area(s)	☐	☐	
Control swabs	☐	☑	
Fingernail swabs	☐	☑	
Matted hair cuttings	☑	☐	
Pubic hair combings/brushings	☐	☑	
Intravaginal foreign body	☐	☑	
Describe:			
Other types	☑	☐	
If yes, describe:			

3. Oral/genital/anal/rectal samples

	# Swabs	Time collected	Collected by:
Oral			
Vulvar			
Vestibular			
Vaginal			
Cervical			
Anal			
Rectal			
Penile			
Scrotal			

4. Vaginal wet mount slide

	No	Yes	Time	Examiner:
Slide prepared				

N. TOXICOLOGY SAMPLES

	No	Yes	Time	Collected by:
Blood alcohol/toxicology (gray top tube)				
Urine toxicology				

O. REFERENCE SAMPLES

	No	Yes	Collected by:
Blood (lav top tube)			
Blood (yellow top tube)			
Blood Card (optional)			
Buccal swabs (optional)			
Saliva swabs			
Head hair			
Pubic Hair			

P. PHOTO DOCUMENTATION METHODS

	No	Yes	Digital	Macrolens	Videocamera	
Body	☐	☐	☐	☐	☐	☐
Genitals	☐	☑	☐	☐	☐	☐

Photographed by: A - Palmer FNE A//

Q. FINDINGS AND INTERPRETATION

1. Anal-Genital Findings
   - ☐ Normal anal-genital exam
   - ☑ Abnormal anal-genital exam
   - ☐ Indeterminate anal-genital exam
2. Assessment of Anal-Genital Findings
   - ☑ Consistent with history
   - ☐ Inconsistent with history
   - ☐ Limited/insufficient history
3. Interpretation of Anal-Genital Findings
   - ☐ Normal exam; can neither confirm nor negate sexual abuse
   - ☐ Non specific; may be caused by sexual abuse or other mechanisms
   - ☑ Sexual abuse is highly suspected
   - ☐ Definite evidence of sexual abuse and/or sexual contact
4. ☑ Need further consultation/investigation
5. ☑ Lab results or photo review pending (may alter assessment)
6. Additional comments regarding findings, interpretations, and recommendations:

See documentation

R. MEDICAL LAB TESTS PERFORMED

STI Cultures	GC	Chlamydia	Other	Describe:	Collected by:
Oral	☑	☑	☐		
Vestibular	☐	☐	☐		
Vaginal	☐	☐	☐		
Cervical	☑	☑	☐		
Anal	☐	☐	☐		
Penile	☐	☐	☐		
	☐	☐	☐		

Serology Syphilis ☑ Hepatitis ☐
Pregnancy test Blood ☐ Urine ☐
Other test(s)

S. PRINT NAMES OF PERSONNEL INVOLVED

History taken by: A. Palmer
Exam performed by: A. Palmer
Specimens labeled and sealed by: A. Palmer
Assisted by: N/A
Signature of examiner: A. Palmer FNE A//

T. EVIDENCE DISTRIBUTION

Clothing item(s) not placed in evidence kit
Evidence Kit
Reference blood samples
Toxicology samples

U. SIGNATURE OF OFFICER RECEIVING EVIDENCE

Signature: See W/C
Print name and ID#:
Agency:
Date: Telephone:

Popovich, Alicia Marie
Account # A089774276
Medical Rec # M0853788
Service/Admit Date
Birthdate 01/11/1993
F 28

A089774276

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400 West 7th Street
Frederick, MD 21701
240-566-3300

Cranial Nerve Assessment

Nerve	Assessment	Notes
CN I Olfactory	Identifies a familiar scent with eyes closed (coffee).	☑ WNL ☐ Unable to assess
CN II Optic	Read one eye at a time. Visual fields tested by having patient cover one eye and identify number of fingers in each visual field.	☐ WNL ☑ Unable to assess (R) eye swollen shut
CN III Oculomotor	Check pupillary response with light. Check accommodation by moving your finger towards the patient's nose. Check for EOMs.	☐ WNL ☑ Unable to assess couldn't open (R) eye
CN IV Trochlear	Have patient look down and in.	☐ WNL ☑ Unable to assess
CN V Trigeminal	Ask patient to open mouth while you attempt to close it. Have them attempt to move jaw laterally. Have patient close their eyes. Touch their face with cotton and have patient identify where they were touched.	☐ WNL ☑ Unable to assess couldn't open too painful
CN VI Abducens	Have patient move their eyes from side to side.	☐ WNL ☑ Unable to assess
CN VII Facial	Ask patient to smile and raise eyebrows. Ask them to keep eyes and lips closed while you try to open them.	☐ WNL ☐ Unable to assess
CN VIII Acoustic/ Vestibular	Test hearing with rubbing fingers or whispering.	☑ WNL ☐ Unable to assess
CN IX Glosso-pharyngeal	Observe patient swallow, and check gag reflex.	☑ WNL ☐ Unable to assess
CN X Vagus	Assess gag and swallowing with IX. Assess patient's voice characteristics.	☑ WNL ☐ Unable to assess
CN XI Spinal Accessory	Have patient shrug shoulders with resistance. Have patient move head from side to side.	☑ WNL ☐ Unable to assess
CN XII Hypoglossal	Have patient stick out tongue and move it internally from right to left. Assess articulation.	☑ WNL ☐ Unable to assess

☐ Cranial nerve assessment normal
Describe abnormalities: swollen (R) eye, too painful to open mouth

FNE Signature: [signature] FNE A/P Date/Time: 2/4/01 1C 1NW

Popovich,Alicia Marie
Account# A089774276
Medical Rec # M0853788
Service/Admit Date
Birthdate 01/11/1993
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A089774276 A089774276

FREDERICK HEALTH HOSPITAL
400 West 7th Street
Frederick, MD 21701
240-566-3300

EVIDENCE COLLECTION CHECKLIST

Case # 21-49724

ITEM	COLLECTED?	Collected By
Exam Consent form Signed	(YES) NO N/A	
FMH Examination Forms	(YES) NO N/A	
Known Blood Sample	(YES) NO N/A	
Oral Swabs (2)	(YES) NO N/A	
Bite Mark / Licking Swab (2): From _____	YES NO N/A	—
Miscellaneous (2): From DNA neck	(YES) NO N/A	
Miscellaneous (2): From DNA	(YES) NO N/A	
Debris Collection: From _____	YES NO N/A	
Fingernail Swabs (2)	(YES) NO N/A	
Pubic Hair Combing	(YES) NO N/A	
External Genitalia Swabs (2)	(YES) NO N/A	
First Vaginal Swab (1)	(YES) NO N/A	
Anal / Perianal Swabs (2)	(YES) NO N/A	
Vaginal / Cervical Swabs (3)	(YES) NO N/A	
Urine for DFSA	YES NO (N/A)	\
Grey Top Blood Tube for DFSA	YES NO (N/A)	\
Clothing Bag (item _____)	YES NO (N/A)	police took Clothing
Clothing Bag (item _____)	YES NO N/A	
Clothing Bag (item _____)	YES NO N/A	
Clothing Bag (item _____)	YES NO N/A	
Chart Copy - MSP Kit ***	(YES) NO N/A	
Chart Copy - Police ***	(YES) NO N/A	
Photo Memory Card or DVD	YES NO (N/A)	—
Photo Record (# pgs 1)	(YES) NO N/A	
Other _____	YES NO (N/A)	\
	YES NO N/A	
	YES NO N/A	
	YES NO N/A	
	YES NO N/A	

Printed Name: A. Palmer FNE A/P Initials/Signature: [signature] Date 7/4/21 Time 1400

Popovich, Alicia Marie
Account # A089774276
Medical Rec # M0853788
Service/Admit Date
Birthdate 01/11/1993
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A089774276

FREDERICK HEALTH HOSPITAL
400 West 7th Street
Frederick, MD 21701
240-566-3300

FORENSIC NURSE EXAMINER PHOTO RECORD

Photographer: A. Palmer FNE A/P Camera: Cortex - Flo

Total Number of Photos: 95

NO.	SUBJECT AND REMARKS
1	ID
2 - 44	Face, neck, back
45 - 46	hands
47 - 73	legs -
74 - 85	buttocks
86 - 89	vagina
90 - 92	error
93 -	error

Frederick Health

Patient: Alicia Marie Popovich
Acct Num: A089774276
Med Rec Num: M0853788
Location: NUR-Emergency Dept
Primary Provider: Delauter,Daniel A
Date: 07/04/2021

Patient Signature Page

Patient Name: Alicia Marie Popovich
Guardian Name:

You were seen today for:

Assault

Your caregivers today were:

Primary Provider: Daniel A Delauter , CRNP
Nurse: LAC

The above-named patient and/or guardian has received the following

Patient Instructions:

Received with this packet on 07/04/2021 at 12:53
Follow-Up Instructions-Child Sexual/Abuse/Assault
HIV Testing Information Sheet

Activity Restrictions or Additional Instructions:

Please follow-up as directed by the safe nurse.

Return here for any new or worsening symptoms.

Follow-Ups:

Alicia Marie Popovich has been referred to the following clinics/specialists for follow-up care:

1. PCP Unknown Date:

Additional Documents Given:

Antibiotic Stewardship
Prescription Notifications
Other Instructions - ED

Frederick Health

Patient: Alicia Marie Popovich
Acct Num: A089774276
Med Rec Num: M0853780
Location: NUR-Emergency Dept
Primary Provider: Delauter,Daniel A
Date: 07/04/2021

Home Medications List
Discharge Care Plan
Tests Not Yet Complete

I have read and understand the instructions given to me by my caregivers.

Alicia Marie Popovich
Print Patient Name

Patient (or Guardian) Signature — 7-4-21 c 1319 Date/Time

Caregiver/RN/Doctor Signature — 7/4/21 c 1319 Date/Time

Printed on 07/04/2021 at 12:53


PENGAD 800-631-6989
STATE'S
EXHIBIT
27
6/17/23
C10CR21-535